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GENDER DYSPHORIA IN CHILDREN –

'GILLICK' COMPETENCE & THE BEST INTERESTS DEBATE

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Transgender and gender dysphoria issues – and recognition, support, and assistance for transgender minors – is increasingly a political and ideological debate which ignores the needs of the people affected. There is a Bill before the New South Wales Parliament "to prohibit schools, teachers, and training courses from teaching gender fluidity" which demonstrates the divisive nature of the ongoing debate.[ii] On 15 June 2021, the Australian Senate also briefly debated and voted, on "conscience" lines, a Motion which would have further condemned children receiving "experimental and unproven medical treatments of irreversible puberty blockers and sex hormone treatments, and irreversible transgender surgery".[iii] The motion was defeated.

The informed decision-making capacity of children who seek medical treatment for gender dysphoria ('GD') has consequently become a topic of controversy. "Gender dysphoria" in children is designated in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) as 'a marked incongruence between one's experienced/expressed gender and assigned gender, lasting at least 6 months' as manifested by six of the criteria specified by DSM-5.

In 1986, the English House of Lords decision of *Gillick v West Norfolk and Wisbech Health Authority* [1986] AC 112 *('Gillick')* became the seminal case in assessing the capacity of minors to give consent to invasive medical procedures. *Gillick* was not a case involving gender, but rather the issue of obtaining consent in prescribing contraception to a person under the age of 18. *Gillick* principles are however relevant to whether persons under 18 who seek treatment for GD hold the requisite capacity to understand both stages of treatment and therefore the competence to give their consent.

A The *Gillick* Decision and Its Impact

In *Gillick*, the House of Lords considered whether doctors could prescribe contraceptives to young women (under the age of 16), absent parental consent. The answer turned on the ability of the child to consent to and comprehend the proposed treatment, and in this way *Gillick* openly raised the question of where parental authority ends. Scarman LJ at [186], stated that ‘parental right yields to the child's right to make his own decisions when he [or she] reaches a sufficient understanding and intelligence to be capable of making up his [or her] own mind on the matter requiring decision’. Notably, *Gillick* places no limit on the nature of the ‘matter’ that a child might be competent to decide. The High Court of Australia in *Marion’s case* largely adopted the *Gillick* precedent into Australian law in 1992.[iv] It was held that the non-therapeutic sterilisation of an intellectually disabled girl under the age of 18 was outside the scope of parental power to consent to medical treatment, and that the child was not, and could never be, *Gillick* competent.

One would expect that the Court need not play a role where:

(a) both parents acknowledge their child’s *Gillick* competency to make a decision different from the decision they would make for the child; or

(b) where a Gillick-competent child and both parents agree on a decision.

This is not the case. Under Australian law there is a category of ‘special medical procedures’ for which a parent cannot make a decision on behalf of their child, *Gillick* competent or not.[v] The High Court conclusion at [250] in *Marion’s case* was that the scope of parental authority did not extend to special medical procedures like sterilisation and court authorisation was required as it necessitated "invasive, irreversible and major surgery".[vi] Further, that there is a ‘significant risk of the parents making a wrong decision’ about both the child's present and future capacity to consent, and ‘the particularly grave consequences of a wrong decision’ given the procedure involved.[vii]

It followed from *Marion’s case* that in such cases, and where a child is unquestionably not Gillick-competent, this matter falls outside parental authority, and court authority for the procedure must be obtained. The Family Court’s power to make this decision derives from section 67ZC of the *Family Law Act 1975* (Cth) (‘FLA’) – the so-called ‘welfare power’.[viii]

This was evidenced in *Marion's case* by the High Court's use of the 'best interests of the child' as the paramount principle in decision making. In view of *Marion's case*, how do *Gillick* and 'best interests' principles apply to the medical treatment that GD children seek? As held at [259], 'the issue for the court in considering whether to consent to a sterilisation [or GD] procedure is whether in all the circumstances of the particular child the procedure is in the child's best interests.'

While not a case that deals explicitly with GD, *Gillick* has informed how the Court interprets the competency of minors for the purposes of Stages 1 (puberty blockers) & 2 (cross-hormone therapy) of GD treatment. Prior to 2017, the subject of competency was dominated by the requirement for court authorisation for Stage 2. This compounded delays, costs and was a great imposition of the resources of treating teams that were required to write detailed court reports for each new proceeding.

B Australian Precedent

Re Jamie (2013) and (2015); *Re Kelvin* (2017)

In Australia there is clear law to the effect that a child's right to decide is only limited by parental authority until such time as the child attains *Gillick* competency.[ix] Thus, parental authority ceases when a child achieves competency in relation to a particular matter. To this end, if the dispute concerns Stage 2 GD treatment, the Family Court has generally proceeded on the basis that *Gillick* competency applies, and that a child's wishes, regardless of age, must be subject to the court's view of their 'best interests'.

Initially in Australia, the Full Court of the Family Court classified medical treatment for GD under the same umbrella term *Marion's case* used for sterilization – 'a special medical procedure'. This led to GD treatment being labelled as non-therapeutic and court authorisation being required in place of parental consent.

This was challenged in *Re Jamie* [2013] FamCAFC 110, [17] *('Re Jamie')*. The Full Court of the *Re Jamie* (2013) held Stage 1 treatment to not be a "special medical procedure" of the kind described in *Marion's case*. Bryant CJ, Finn & Strickland JJ affirmed Marion's case for Stage 2, finding that court authorisation for parental consent remained appropriate unless the child was *Gillick* competent.

The Full Court in *Re Jamie* (2015) agreed with the 2013 findings of the trial Judge (Finn J) at [182] – "…although [Stage 2 treatment] was therapeutic in nature, it was also irreversible". As the Court made a finding of *Gillick* competence, this led to the conclusion at [81] to [83] that Jamie was competent to fully understand the nature and consequences of the treatment and make her own decision regarding it.

This decision has proved problematic. While the Full Court recognised that Stage 2 treatment is therapeutic it concluded that court authorisation was still required due to the 'irreversible' nature of treatment. In essence, Stage 2 was deemed a 'special medical procedure'. While recognising that *Gillick*-competent children like Jamie could consent, it held that only the court could determine the child's *Gillick*-competency – even where there was no parental or medical dispute as to competency.
Following widespread criticism, in 2017 *Re Kelvin* marked the tipping point for the debate.[x] *Re Kelvin* noted the discrepancy between *Re Jamie* and the High Court test in *Marion's Case* which says nothing about necessitating court intervention to determine a child's competency when it is not in dispute.[xi] The applicant argued at [121] that the "Full Court in *Re Jamie* incorrectly interpreted and applied the principles in *Marion's case* [as it's] plurality only dealt with [non-therapeutic] sterilisation… and the decision does not provide a basis for requiring court authorisation where treatment is therapeutic".

The Court in *Re Kelvin* held that contrary to *Re Jamie* Stage 2 treatment for transgender youth *does not* require court authorisation.[xii] It was held that the Full Court in *Re Jamie* erred in its application and should not be followed. Further, the two stages were incorrectly distinguished – not by reference to whether the treatment was "therapeutic", as extrapolated by Brennan J in *Marion's case* at [269], but by consequences of the administration of treatment, i.e., whether the effects were irreversible.
Re Kelvin established that court authority is not required for Stage 2 treatment for a child whose parents and treating practitioners agree is *Gillick*-competent. Secondly, if the child is not *Gillick* competent, but the practitioners agree, the parents can consent on the child's behalf without court approval. This is affirmed by the latest Australian precedent, *Re Imogen (No.6)*.[xiii]

C Our New Reality

Re Imogen (No 6) **(2020);** ***Bell v Tavistock*** **(2020)**

In *Re Imogen (No.6)* the Court made a finding of *Gillick* competent to enable treatment decisions relating to the adolescent's GD. At the time of the trial, September 2019, Imogen was aged 16 years and 8 months. Imogen's mother disputed Imogen's diagnosis and did not agree with treating practitioners that Imogen was *Gillick* competent for the purposes of consenting to Stage 2 treatment. Justice Watts authorised the proposed Stage 2 treatment by order of the Court consistent with its welfare power (section 67ZC of the FLA).

Paraphrasing his Honour's conclusions at [35], in line with the current laws:

a. If a parent or practitioner of an adolescent disputes:

i. Gillick competence, or

ii. a GD diagnosis, and

iii. proposed treatment,

a court application is mandatory.

b. If the only dispute is Gillick competence, the court can make a declaration to that effect (section 34(1) of the FLA), and if this is done "the adolescent is left to determine their treatment without court authorisation".

His Honour found Imogen to be Gillick competent to provide consent, making an order authorising treatment at [198] to [199] as it was in Imogen's "best interests".

The recent landmark decision of *Bell v Tavistock* ('*Bell*') in the UK High Court of Justice is an administrative case that sets out the matters that a child would have to understand, retain, and weigh up in order to have the requisite competence in relation to Stage 1 of treatment.[xiv] The case scrutinised the procedural processes of the Tavistock treating facility and its Gender Identity Development Service ('GIDS'), questioning whether informed consent is in fact sufficient to administer stages of treatment if a child has not been deemed *Gillick* competent. Further, whether Court authorisation should be mandated in the transition between treatments, or whether Court approval should not be required for Stage 2 where the child is *Gillick* competent and there is no dispute (as held in *Re Kelvin*).

The Tavistock program GIDS prescribed puberty blockers and then cross hormone therapy to the claimant Ms Bell, who was born female. The claimant then made the transition to male including a double mastectomy. In their early 20's, they stopped taking testosterone and wished to reidentify as a female – they accused GIDS of giving misleading and inadequate information to form the basis of informed consent – which was later disproved – but their argument that persons aged 16 and under cannot be *Gillick* competent for the purpose of being prescribed PBs was largely held in *Bell* at [90] to [92].

The UK High Court held that persons under 16 can only consent to puberty blockers when *Gillick* competent to understand the nature of the treatment proposed, with "enormous difficulties" in their ability to weigh up the immediate and long-term consequences of even Stage 1 of treatment.

In the *Bell* judgment delivered on 1 December 2020, it was held to be highly unlikely that a child aged 13 or younger could be *Gillick* competent to consent to puberty blocking treatment. The court concluded at [151]:

> *"…It is doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences..".*

In respect of persons 16s and over, the court concluded at [152]:[xv]

> *"…there is a presumption that they have the ability to consent to medical treatment… we recognise that clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment."*

The Court also formed a set of criteria to assess the capacity of those seeking treatment through Tavistock and GIDS which needs to be satisfied to progress through each of the treatment stages. In the immediate aftermath of the judgement, there were many reports of existing GIDS patients having their treatment abruptly cut off and the care for patients over the age of 16 also being negatively affected.[xvi]

It is prudent to note that one of the presiding judges in *Bell*, Justice Lievan, also presided over the UK GD case *AB v CD* earlier this year.[xvii] The child in *AB v CD,* known by the

pseudonym *'XY'*, had provided consent to Stage 1 prior to *Bell* but a clinical review of their capacity based on the *Bell* criteria had not yet occurred. This related to the requirement of a "best interests" Court application for each patient currently receiving treatment if a clinical review by the University College London NHS Foundation Trust had determined that the patient should continue with Stage 1 of treatment. This requirement was introduced by NHS England ("NHSE") shortly after *Bell*.[xviii]

There was unanimity between XY, the clinicians, and the parents, that XY should continue to be prescribed Stage 1 puberty blockers while the clinical review was pending. In a judgment issued on 26 March 2021, the court ruled at [69] that:

> *"…whether or not XY is Gillick competent to make the decision about puberty blockers, her parents retain the parental right to consent to that treatment."*

It was held that "this approach protects the rights both of the child and the parents" pursuant to section 3 of the *Children Act 1989*, Article 8 *ECHR*, and Article 5 *UNCR*.

Following hot on the heels of *Bell v Tavistock*, the court in *AB v CD* carefully reviewed the *Gillick* decision and concluded that the parental right to consent to treatment continues <u>even</u> when a child is *Gillick* competent, save where the parents are seeking to override the decision of the child. This is somewhat different from the stance of Justice Leivan in her *Bell v Tavistock* judgement. However, *AB v CD* does not overrule nor have any legal effect on *Bell* as Justice Lievan neatly covered her bases with an exclusion in her judgement, stating:

> *"Nothing that is said below is intended to depart, to even the smallest extent, from anything that was said in <u>Bell</u>." [9]*

Unlike *Re Imogen (No.6)* and *Re Kelvin*, *Bell* declared Stage 1 treatment a "special category" at [134] to [137]. This reverses the progression of GD precedent all the way back to 1992 by classifying Stage 1 of treatment as a 'special medical procedure' of the kind described in *Marion's case* which necessitates court approval. The Court in *AB v CD* found that there was no reason to place Stage 1 treatment in a special category where the Court's approval was required. This, however, departs from the approach taken in *Bell*. The *Bell* judgement focused heavily on the 'irreversible' nature of treatment, just as *Re Jamie* did.

If it is ‘highly unlikely’ that a 13 year could give informed consent and ‘doubtful’ that a child aged 14 or 15 could weigh up the long-term implications of treatment, *Bell* will make it very difficult in practice to establish *Gillick* competence for the treatment of minors. The complexities of GD are understood by the Full Court in *Bell* but employing a test of reversibility is not the same as employing a test of comprehension. Not only is this misaligned with the *Marion's case* test, but *Bell* is a significant review of *Gillick* – the principle for testing GD treatment comprehension in all our above-mentioned Australian precedent – and not in a good way.

While much consideration is given to the effects of puberty blockers, and their ‘irreversible effects’, the proceedings showcase a startling lack of consideration as to what happens to those minors affected by GD who do not receive puberty blockers. If perhaps The Tavistock Clinic put forward an argument acknowledging the severe harm that occurs to trans youth who are forced to go through puberty without blockers, and the irreversible body changes that may identify them as trans forever, perhaps *Bell* may have been decided differently.

Acknowledging the decision-making capacity of GD children without necessitating court and parental approval for either stage of treatment – where *Gillick* competence is present, parties are in agreement, and treatment is deemed to be in a child's ‘best interests’ – is beyond crucial for the well-being of minors experiencing GD.

Bell is currently the subject of an appeal to the Court of Appeal and is listed for hearing across June 24 and 25th 2021 at which time we hope the law will become clearer regarding exactly whose consent is being relied upon to make the administration of each stage of treatment ‘lawful’. If its appeal is overturned, *Bell* will have a damaging influence upon future GD cases in the UK and internationally. If adopted into Australian precedent, it will undermine *Gillick* principles regarding the capacity of GD minors to consent to medical treatment for GD and instigate a regression from affirming precedents like *Re Kelvin*. Central issues relating to the scope of parental consent and the ‘approval’ role of the court

have become live ones and, unless the appeal is successful, *Bell* threatens to turn our well-established Australian GD precedent and principles 'on their head'.

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[i] Paralegal, Blanchfield Nicholls Family & Private Advisory, 2021.

[ii] *Education Legislation Amendment (Parental Rights) Bill 2020 (NSW)***.**

[iii] The whole motion reads:

That the Senate—

(a) notes that:

i. 100 years of diagnostic history of childhood gender dysphoria (GD) there is an alarming trend that teenage girls, with no history of GD, have become the largest group seeking treatment,

ii. in the United States of America, girls requesting gender reassignment surgery in 2016-17 rose 400%,

iii. in the United Kingdom, girls presenting with GD in the last 10 years rose 4000%, and individual. Australia's Royal Children's Hospital indicates referrals have grown from 1 every two years to 104 patients in 2014;

(b) further notes that:

i. Sweden's leading gender clinic has ended treatment of minors with hormonal drugs due to safety concerns, citing cancer and infertility, and

ii. suicide mortality rate for transgendered people is 20 times higher than comparable peers;

(c) supports children presenting with GD to be given:

i. the 'wait and see' method as the first choice, since evidence shows between 70-90% of young people's dysphoria resolves itself by puberty, and

ii. a comprehensive therapeutic pathway since a large percentage of these children have pre-existing mental health issues, and not a medical pathway; and

(d) condemns the practice of children receiving:

i. experimental and unproven medical treatments of irreversible puberty blockers and sex hormone treatments, and

ii. irreversible transgender surgery.

[iv] *Secretary of the Department of Health and Community Services v JWB and SMB* [1992] HCA 15; (1992) 175 CLR 218 (*'Marion's case'*).

[v] Ibid.

[vi] Ibid 250.

[vii] Ibid 250, 253.

[viii] Lisa Young, 'Mature Minors and Parenting Disputes in Australia: Engaging with the Debate on Best Interests v Autonomy' (2019) 42(4) *UNSW Law Journal 1362,* 47.

[ix] House of Lords decision in *Gillick* [1985] UKHL 7; [1986] AC 112.

[x] [2017] FamCAFC 258.

[xi] [2017] FamCAFC 258.

[xii] [2013] FamCAFC 110.

[xiii] [2020] FAMCA 761.

[xiv] *Bell v Tavistock* [2020] EWHC 3274.

[xv] Section 8 *Family Law Reform Act 1969*; *Re W. (A Child)* [2004] EWCA Civ 1366.

[xvi] Jasmine Anderson, *Families of trans children 'broken' after sudden puberty blockers rule changes* (8 December 2020) iNews (Health) < https://inews.co.uk/news/health/puberty-blockers-ruling-change-transgender-families-reaction-gids-ngs-785232 >.

[xvii] [2021] EWHC 741 (Fam).

[xviii] Amendment to *Gender Identity Development Service Specification for Children and Adolescents* ('GIDS') (E13/S(HSS)/e). Effective 1 December 2020.